4. The sum of the facility's Net Other Operating Expenses per day and its Allowable Administrative and General per diem equals the facility's preliminary Other Operating Cost per diem.

5. The Division will calculate an Other Operating Cost Ceiling as follows:

a. The Division will calculate the 1998 Other Operating Cost per diem for all facilities.

b. The Other Operating Ceiling equals the industry median plus 6%, or $54.14.

6. A facility's Allowable Other Operating Cost is the lower of its preliminary Other Operating Cost per diem or the ceiling.

7. The Division will apply a Cost Adjustment Factor of 7.59% to Allowable Other Operating Costs.

(b) Other Operating Cost Transition Payment.

1. The Other Operating Cost Payment for Payment Groups JK through T will be the sum of (a) 80% of the Other Operating Standard Payment and (b) 20% of the facility's Allowable Other Operating Costs, adjusted for inflation.

2. The Other Operating Cost Payment for Payment Group H is the Standard Payment, $54.96.

6.05 Capital

(1) Capital Payment. There will be a capital payment of $18.24 for

(a) New Facilities and Licensed Beds that become operational on or after January 1, 2001 and are:

1. New Facilities constructed pursuant to a Determination of Need approved after March 7, 1996;

2. Replacement facilities replaced pursuant to a Determination of Need approved after March 7, 1996;

3. New Facilities constructed in Urban Underbedded areas exempt from the Determination of Need process;

4. New beds licensed pursuant to a Determination of Need approved after March 7, 1996; and

5. New beds in twelve-bed expansion projects not associated with an approved Determination of Need project.

(b) New Hospital-Based Nursing Facilities that become licensed during the Rate Year; and

(c) Private Nursing Facilities which sign a Provider Agreement with the Division of Medical Assistance during the Rate Year.

(2) Capital Payment – Other Facilities. For all other facilities, the Capital Payment is based on the facility's Capital Costs, including allowable depreciation, Financing Contribution, and Other Fixed Costs. (a) Allowable Basis of Fixed Assets.

1. Fixed Assets include Land, Building, Improvements, Equipment and Software.

2. Allowable Basis. The Allowable Basis is the lower of the Provider's actual construction cost or the Maximum Capital Expenditure approved for each category of assets by the Massachusetts Public Health Council and used for Nursing Facility services. The Division will classify depreciable land improvements such as parking lot construction, on-site septic systems, on-site water and sewer lines, walls and reasonable and necessary landscaping costs as Building cost.

3. Allowable Additions. The Division will recognize Fixed Asset Additions made by the Provider if the Additions are related to the care of publicly-assisted Residents. If Additions

relate to a capital project for which the Department has established a Maximum Capital Expenditure, the allowable amount will be limited to the amount approved by the Department. The Division will not recognize Fixed Asset Additions made or Equipment Rental expense incurred within 12 months after a DON project becomes operational.

4. Change of Ownership. If there is a Change of Ownership, the Allowable Basis will be determined as follows:

a. Land. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis.

b. Building. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June, 30, 1976 and 1993 forward.

c. Improvements. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

d. Equipment. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

e. Upon transfer, the seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

f. If the Division cannot determine the amount of actual depreciation allowed in a prior year from its records, the Division will determine the amount using the best available information including, among other things, documentation submitted by the Provider.

5. Special Provisions.

a. Non-Payment of Acquisition Cost. The Division will reduce Allowable Basis if the Provider does not pay all or part of the acquisition cost of a reimbursable fixed asset or if there is a forgiveness, discharge, or other non-payment of all or part of a loan used to acquire or construct a reimbursable fixed asset. The Division will reduce the basis to the extent that the basis was derived from the acquisition or construction cost of the fixed asset.

b. Repossession by Transferor. The Division will recalculate Allowable Basis if a transferor repossesses a facility to satisfy the transferee's purchase obligations; becomes an owner or receives an interest in the transferee's facility or company, or acquires control of a facility. The Allowable Basis will not exceed the transferor's original allowable basis under Division regulations applicable at the date of Change of Ownership , increased by any allowable capital Improvements made by the transferee since acquisition, and reduced by depreciation since acquisition.

(b) Capital Costs. The Division will calculate the Provider's Capital Costs including depreciation, Financing Contribution, and Other Capital Costs as defined below.

1. Depreciation. The Division will allow depreciation on Buildings, Improvements and Equipment based on the Allowable Basis of Fixed Assets as of December 31, 1998. Depreciation of Buildings, Building Improvements, and Equipment will be allowed based on generally accepted accounting principles using the Allowable Basis of Fixed Assets, the straight line method, and the following useful lives:

LIFE	YEARS	RATE
Buildings and Additions	40	2.5%
Building Improvements	20	5%

Equipment, Furniture and Fixtures	10	10%
Software	3	33.3%

2. Financing Contribution. The Division will calculate a Financing Contribution by multiplying 7.625% by the Allowable Net Book Value as of December 31, 1998. The Allowable Net Book Value is the allowable basis less all accumulated depreciation calculated for the period through December 31, 1998, except allowed Building depreciation expense which occurred between January 1, 1983 and December 31, 1992.

3. Rent and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment at the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.

4. Capital Costs. The Division will calculate the Provider's Capital Costs by adding allowable 1998 depreciation and Other Fixed Costs and the Financing Contribution.

5. Capital Cost Per Diem. The Division will calculate the Provider's 1998 Capital Cost per diem by dividing 1998 Capital Costs by the greater of 96% of Constructed Bed Capacity times 365 or the Actual Utilization Rate in 1998.

6. For Providers with a revised Capital Payment for a substantial capital expenditure in 1999 or 2000, the Division will calculate Capital Costs using the year end Allowable Basis and Net Book Value, revised constructed bed capacity, and revised Actual Utilization Rate. This does not apply to Providers with a revised Capital Payment of $17.29.

(c) Determination of Capital Payment. For beds licensed prior to 2001, the Capital Payment will equal the facility's capital payment in its certified rates effective December 30, 2000, calculated as follows:

1. If the Provider's 1999 Capital Payment is lower than $17.29, and its Capital Cost per diem is greater than $17.29, its 2000 Capital Payment is $17.29.

2. If the Provider's 1999 Capital Payment is lower than $17.29, and its Capital Cost per diem is lower than $17.29, its 2000 Capital Payment is its Capital Cost per diem.

3. If the Provider's 1999 Capital Payment is greater than or equal to $17.29, and its Capital Cost per diem is greater than $17.29, its 2000 Capital Payment is the greater of $17.29 or 90% of its Capital Cost per diem.

4. If the Provider's 1999 Capital Payment is greater than or equal to $17.29, and its Capital Cost per diem is lower than $17.29, its 2000 Capital Payment is its Capital Cost per diem.

5. If a Provider relicenses beds in 2001 which were out of service, its 2001 Capital Payment will be the lower of $17.29 or the facility's most recent billing rates for Fixed Costs and Equity or Use and Occupancy.

(d) Capital Payment Adjustment.

1. Qualifying Providers. The Division will include a Capital Payment Adjustment for Providers that meet the following criteria:

a. the 1999 Capital Payment exceeds the Capital Cost per diem calculated under 114.2 CMR 6.05(2)(b)5;

b. the difference between the 1999 Capital Payment and the Capital Cost per diem, multiplied by 1998 Medicaid patient days, exceeds $100,000.

2. Determination of Adjustment. For qualifying Providers, the Division will calculate the Capital Payment Adjustment as follows:

a. 1998 Capital per diem. The Division will calculate a capital per diem including 1998 long term interest, building insurance, real estate taxes, and equipment rental. Long Term Interest will be limited to the proportion of reported interest supported by allowable depreciable fixed assets as of the date the Provider obtained its long term financing. The divisor will be the greater of 96% of Constructed Bed Capacity times 365 or the Actual Utilization Rate in 1998.

2. Preliminary Capital Payment Adjustment. If the 1998 Capital per diem exceeds the Provider's 2000 Capital Payment as determined under 114.2 CMR 6.05(2)(b), the difference is the Preliminary Capital Adjustment.

3. Preliminary Payment Adjustment. For purposes of determining the Capital Payment Adjustment, the Division will apply a Preliminary Payment Adjustment to reflect the percentage change from the facility's weighted preliminary Payments and its weighted current payments.

(i) The Division will calculate preliminary payments for each facility, which are the sum of the Nursing and Other Operating Payments and the Capital Payment prior to the Capital Payment Adjustment.

(ii) The Division will determine the percentage change from the facility's weighted preliminary payment and its weighted current payment. The Division will use the methodology set forth in 114.2 CMR 6.06(1)(b) to calculate the weighted payments.

(iii) If the percentage increase between a facility's 2000 weighted preliminary payment as calculated above and its 1999 weighted current payment is greater than 6%, the adjustment from its 1999 weighted current payment will be limited to 6%, resulting in a negative preliminary payment adjustment. If a facility's 2000 weighted preliminary payment is lower than the facility's 1999 weighted current payment, the facility's 2000 payments will equal its 1999 payments including the 1999 Add-on of $0.76, resulting in a positive payment adjustment.

4. Capital Payment Adjustment.

a. If the Provider's Preliminary Total Payment Adjustment is positive and exceeds the Preliminary Capital Payment Adjustment, the Final Capital Payment Adjustment is zero.

b. If the Provider's Preliminary Payment Adjustment is positive but less than the Preliminary Capital Payment Adjustment, the Final Capital Payment Adjustment will equal the Preliminary Capital Payment Adjustment.

c. The Capital Payment Adjustment is subject to the Total Payment Adjustment under 114.2 6.06(1)(b).

d. The Capital Payment Adjustment is subject to audit by the Division and/or the Division of Medical Assistance to verify amounts reported in the cost reports. The Division may adjust the provider's Capital Payment Adjustment based upon such audits.

(e) Weighted Capital Payment. If a Provider's licensed beds fall into different Capital Payment methods, the Division will calculate the Capital Payment for each type of licensed beds. The Division will weight the capital payment based on the number of licensed beds associated with each type of method.

(3) Revised Capital Payment for Substantial Capital Expenditure.

114. 2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

(a) General Notification Requirements. All Providers must notify the Division when they open, add new beds, renovate or re-open beds. The notification must contain the Provider's name, address and VPN, date of bed change, type of change and description of project.

(b) Request for Revised Capital Payment. A Provider may request a revised Capital Payment for capital costs associated with the change or renovation of licensed beds pursuant to an approved Determination of Need.

1. Facilities that may request a revised Capital Payment include:
   a. New Facilities and newly-licensed beds which open pursuant to a Determination of Need;
   b. Replacement Facilities which open on or after February 1, 1998 pursuant to a Determination of Need;
   c. Facilities with Renovations made pursuant to a Determination of Need;
   d. Facilities with twelve bed additions associated with a Determination of Need; and
   e. Facilities which requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).
2. If a Provider listed in 114.2 CMR 6.05(3)(b)1 requests a revised Capital Payment to reflect a change in beds, it must submit the following:
   a. a description of the project;
   b. a copy of the construction contract;
   c. copies of invoices and cancelled checks for construction costs;
   d. a copy of the Department's licensure notification associated with the new beds; and
   e. a copy of the mortgage.

   The Division may request further information it determines necessary to calculate a revised Capital Payment.
3. The Division will certify a temporary Capital Payment of $18.24 upon receipt of the notification of the change in beds, rate adjustment request, and required supporting documentation.
4. In order to calculate the final revised Capital Payment, the Division will determine the amount of new allowable assets and apply the Financing Factor in 114.2 CMR 6.05(2)(b)2.

(c) Revised Capital Payment.

1. For the Providers specified in 114.2 CMR 6.05(1)(a), the Division will certify a Capital Payment of $18.24.
2. For the following facilities, the final revised Capital Payment will be the greater of 90% of the amount calculated under 114.2 CMR 6.05(3)(b)4 or $18.24:
   a. New Facilities and newly-licensed beds which open pursuant to a Determination of Need approved on or before March 7, 1996;
   b. Replacement Facilities which open on or after February 1, 1998 pursuant to a Determination of Need approved on or before March 7, 1996;
   c. Facilities with twelve bed additions associated with a Determination of Need approved on or before March 7, 1996; and
   d. Facilities which requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).
3. For the following facilities, the revised Capital Payment will be the lower of the amount calculated under 114.2 CMR 6.05(3)(b)4 or $18.24:

a. facilities which renovate pursuant to a Determination of Need approved after March 7, 1996; and

b. facilities that implement a transferred Determination of Need approved before March 7, 1996 but did not file a Notice of Intent to Acquire the facility before March 7, 1996. This provision will not apply if the transfer occurred on or after February 1, 1998 and before May 30, 1998. If the transfer occurred during this period, the revised Capital Payment will be determined under 114.2 CMR 6.05(3)(c)1.

4. For Facilities with Renovations made pursuant to a Determination of Need approved before March 7, 1996, if the revised amount calculated under 114.2 CMR 6.05(3)(b)4 is greater than $18.24, the Capital Payment will be the 90% of the amount calculated under 114.2 CMR 6.05(3)(b)5. If the calculated amount is lower than $18.24, the Capital Payment will be the amount calculated under 114.2 CMR 6.05(3)(b)4.

(d) Effective Date. The effective date of the revised Capital Payment will be the date upon which the Provider submits the notification and all information and documentation required in 114.2 CMR 6.05(3)(b)2.

6.06 Other Payment Provisions

(1) Transition Payments. Transition Payments are the sum of the Payments for Nursing, Other Operating Costs, and Capital, subject to the Total Payment Adjustment.

(a) Preliminary Payments. The Division will calculate preliminary payments for each facility, which are the sum of the Nursing and Other Operating Payments and the Capital Payment, including the Capital Payment Adjustment under 114.2 CMR 6.05(2)(d). For hospital-based nursing facilities, the preliminary payments are the sum of the Standard Payments for Nursing and Other Operating Costs and the Capital Payment of $17.29 per day.

(b) Total Payment Adjustment. There is an additional adjustment to reflect the percentage change from the facility's 2001 weighted Preliminary Payments and its weighted current payments.

1. Weighted Current Payment. A facility's current payments are its most recently certified payments effective December 1, 2000 less the 2000 C N A wage add-ons. The Division will calculate the weighted 2000 current payment using second quarter 2000 case mix proportions. The "weighted current payment" is the sum of the products of each category's current payment by its corresponding case mix proportions.

2. Weighted Preliminary Payment. The Division will calculated the weighted Preliminary Payment using second quarter 2000 case mix proportions. The "weighted preliminary payment rate" is the sum of the products of each category's preliminary 2001 payment by its corresponding case mix proportions.

3 Determination of Total Payment Adjustment.

a. If the percentage increase between a facility's 2001 weighted preliminary payment and its 2000 weighted current payment is greater than 6%, the facility's payment adjustment from its 2000 weighted current payment will be limited to 6%.

b. If the percentage increase between a facility's 2001 weighted preliminary payment and its 2000 weighted current payment is between 2% and 6%, there will be no payment adjustment.

c. If the percentage increase between a facility's 2001 weighted preliminary payment and its 2000 weighted current payment is less than 2%, the facility's payment adjustment from its 2000 weighted current payment will be 2%.

d. The Total Payment Adjustment will not be recalculated as a result of revised Capital Payments for a substantial capital expenditure.

(c) Add-on for Certified Nursing Assistants. Pursuant to Chapter 159 of the Acts of 2000, line item 4000-1005, the Division will include an additional Add-on for Certified Nursing Assistants. This add-on is for the purposes of funding increases in Certified Nursing Assistant salaries and associated payroll taxes. The add-on is not subject to the Total Payment Adjustment. Any Provider that failed to file a required 1998 or 1999 cost report will not be eligible for this add-on.

1. Calculation of the Add-on.

a. For each Provider, the Division will determine the total reported 1998 Certified Nursing Assistant Salaries.

1. If the Division used a short year 1998 cost report to calculate the Provider's 2000 rate, the Division will annualize the reported Certified Nursing Salaries for that Provider.

2. If a Provider opened in 1999, the Division will calculate the add-on using 1998 median reported Certified Nursing Assistant Salaries.

b. The Division will multiply the Provider's 1998 Certified Nursing Assistant Salary amount by the Provider's 1998 Medicaid Utilization as reported in the 1998 Cost Report. Medicaid Utilization is Total Reported Medicaid Days divided by Total Reported Patient Days.

c. The Division will sum the amount determined in 114.2 CMR 6.06(1)(c)1b for all Providers.

d. For each Provider, the Division will divide the amount determined in 114.2 CMR 6.06(1)(d)1b by the amount determined in 114.2 CMR 6.06(1)(c)1c.

e. The Division will multiply the resulting percentage by $40 million.

f. The Division will divide the amount calculated above by the product of:

1. current licensed bed capacity for the Rate Year times the days in the Rate Year, times

2. reported 1998 Actual Utilization, times

3. reported 1998 Medicaid Utilization.

This amount will be included as an add-on to each Provider's 2001 rate.

(d) Nurses Aide Labor Cost Recovery. Providers must increase amounts spent for Certified Nursing Assistant wages and payroll taxes by the revenue generated by the add-ons. If the Division determines that the Provider has not spent all of the revenue for Certified Nursing Assistant wages and payroll taxes, the Division will notify the Division of Medical Assistance of the amount to recover from the Provider. The Division will determine the amount to be recovered in accordance with the statutory requirements of Chapter 159 of the Acts of 2000, line item 4100-0064, as follows:

1. The Division will multiply the add-on by Medicaid patient days in 2001 to determine the Medicaid revenue generated by the add-on.

2. For the following accounts, the Division will adjust the expense amounts reported in the 1999 cost reports for changes in total patient days between 1999 and 2001, by multiplying the 1999 reported expenses in the following accounts by the ratio of 2001 patient days to 1999 patient days:

Certified Nursing Assistant Salaries	6051.1
Payroll Taxes	4408.2

For the payroll tax account, the Division will allocate the reported amounts based on reported nurses aide salaries to total nursing salaries.

3. The Division will compare the 2001 reported expense to the adjusted 1999 reported expense. If the amount reported in the 2001 cost report does not exceed the adjusted

1999 amount by at least the amount of revenue generated by the add-on, there will be a recovery of 150% of the difference.

4. The Division and/or the Division of Medical Assistance may conduct audits to verify amounts reported in the cost reports.

(2) Retroactive Adjustments. The Division will retroactively adjust payments in the following situations:

(a) Amended Payments for Prior Years. The Division will amend 2001 payments to reflect 1997, 1998, 1999 and 2000 rates amended for the following reasons: offbase and lookback rates pursuant to 114.2 CMR 5.11, administrative adjustments pursuant to 114.2 CMR 5.12; amended rates pursuant to an administrative appeal; amended DON approvals for Maximum Capital Expenditures if the original Determination of Need was approved prior to March 7, 1996, or any further adjustments to reflect the results of any desk or field audits conducted by the Division or the Division of Medical Assistance.

(b) Mechanical Errors. The Division may adjust payments if it learns that there is a material error in the rate calculations.

(c) Errors in the Cost Reports. The Division may adjust payments if it learns that the Provider has made a material error in the cost report.

(3) Ancillary Costs. Unless a Provider participates in the Ancillary Pilot Program with the Division of Medical Assistance, or a Provider's payments include Ancillary Services pursuant to the regulations or written policy of the purchasing agency, the Provider must bill Ancillary Services directly to the purchaser in accordance with the purchaser's regulations or policies.

(4) Residential Care Beds. The Division will establish separate Nursing and Other Operating Costs payments for Residential Care Beds in a dually-licensed facility. The Division will determine the proportion of 1998 reported costs allocable to the rest home beds. It will exclude from the calculation reported costs for Ward Clerk, Utilization Review, Medical Records, and Advisory Physician. Allowable costs will be limited to the 2000 freestanding rest home ceiling established in 114.2 CMR 4.00. The facility's payment for Residential Care Beds will not exceed its 2001 Payment for Payment Group H Nursing Facility Residents, and the rate will not be lower than its certified 2000 payment for Residential Care Beds. The Residential Care Bed payment is not subject to the Total Payment Adjustment set forth in 114.2 CMR 6.06(1)(b).

(5) Reopened Beds Out of Service. Providers with licensed beds that were out of service prior to 2001 which reopen in 2001 will receive the lower of the Standard Payments or the most recent prior payments inflated to 2001 for Nursing and Other Operating Costs.

(6) Pediatric Nursing Homes. Payments to facilities licensed to provide pediatric nursing facility services will be determined using 1998 Reported Costs for Nursing and Other Operating Costs, excluding Administration and General Costs. Administration and General Costs will be based on 1998 costs subject to a cap of $11.48. A pediatric nursing facility may apply to the Division for a payment adjustment for the otherwise unrecognized medical costs of residents over the age of 22 who were previously enrolled in the facility's Chapter 766 program. The Division will calculate an adjustment to include the reasonable costs for these services subject to approval by the Division of Medical Assistance.

(7) Payments for Innovative and Special Programs.

(a) The Division will include an allowance for costs and expenses to establish and maintain an innovative program for providing care to Publicly-Aided Residents if: